STUDENT NAME_____ _____
(Please PRINT) Last First Program

Washington County Career Center - 2017-2018
EMERGENCY MEDICAL AUTHORIZATION FORM

(Ohio Revised Code 3313.712)

Date of Birth_____ Primary Phone_____

Home School_____ Address_____

School Year_____ Grade_____ _____Zip_____

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. This information will be shared with staff who have a legitimate need to know.

RESIDENTIAL PARENT or GUARDIAN:

Mother's Name_____ Primary Phone__( )_____

Father's Name_____ Primary Phone__( )_____

Other Contact Name_____ Primary Phone__( )_____

Please identify any health concerns that school personnel should be aware of:

Allergies: No____ Yes____ Specify_____

Epi-pen: No____ Yes____ *If yes, Epi-pen Authorization Form must be completed.*

Asthma: No____ Yes____ *If yes, Inhaler Authorization Form must be completed.*

Headaches/Migraine: No____ Yes____

Seizures: No____ Yes____ Emergency seizure medications?_____
Name of medications

Diabetes: No____ Yes____ Emergency diabetic medications?_____
Name of medications

Does your student take any medications regularly? No____ Yes____ _____
Name of medication, amount taken, how often

Will your student take medications at school? No____ Yes____ *If yes, Permission to Dispense Medications Form must be completed.*

Are there any other medical conditions that school personnel should be aware of?_____
_____

PART I OR II MUST BE COMPLETED

PART I: CONSENT FOR TREATMENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: 1) the administration of any treatment deemed necessary by the named doctor, or in the event the designated practitioner is unavailable, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of the two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained to the performance of such surgery.

I hereby give consent for the following medical care providers and local hospitals to be called:

Doctor_____ Phone ( )_____

Dentist_____ Phone ( )_____

Hospital_____ Phone ( )_____

_____
Signature of Parent/Guardian Date

PART II: REFUSAL TO CONSENT

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

_____

_____
Signature of Parent/Guardian Date
Sign only if refusal to consent

OVER

If needed, we authorize the nurse to dispense: (Please check each one Yes or No)

Non-Aspirin (Tylenol/Ibuprofen): Yes_____ No_____ Other (Midol, etc): Yes_____ No_____

Neosporin Topical Ointment: Yes_____ No_____ Burn Gel: Yes_____ No_____
(For minor abrasions/infections)

Antacids: Rolaids/Tums/Mylanta, etc.: Yes_____ No_____ Cough Drops: Yes_____ No_____

If needed, the nurse may also:

Irrigate eyes: Yes_____ No_____ Remove splinter: Yes_____ No_____

Basic First Aid: Yes_____ No_____ Remove small foreign objects: Yes_____ No_____

GRANT CONSENT:

I hereby consent to all above information:

Signature of Parent/Guardian_____ Date_____

ALL MEDICATIONS MUST BE KEPT AT THE NURSE'S OFFICE

If medication is to be with the student at all time (i.e. inhaler, epi-pen) a physician's note MUST be brought to the nurse for each medication. The note MUST include: Medication, time, dose, physicians name, address and phone number, and why the medication must be with student at all times.